make up the differences reported in the column for original cost and Medicaid basis.

4-7 COST REPORT FORMS

The Medicaid cost report forms Form 1 through Form 10 are on the following pages.

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
FEDERALLY QUALIFIED HEALTH CENTERS

GENERAL INFORMATION

I. PROVIDER

Provider Name _____ Provider Number _____

D/B/A (If Applicable) _____

Address _____

_____

Administrator _____ Phone _____

Contact Person _____ Title _____ Phone _____

Report Period: From _____ To _____ Number of Months _____

Financial Records For Audit Are Located At _____

_____

_____

II. SATELLITE CLINICS (IF APPLICABLE)

Name of Satellite Clinic _____

Address _____

_____

_____

Contact Person _____ Phone _____

Name of Satellite Clinic _____

Address _____

_____

_____

Contact Person _____ Phone _____

III. FOR DIVISION OF MEDICAID USE ONLY

Date C/R Mailed _____ Received _____

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
FEDERALLY QUALIFIED HEALTH CENTERS

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

Provider Name _____ Provider No. _____
Address _____
_____

The enclosed cost report is submitted for the cost reporting period beginning _____ and ending _____.

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

This Cost Report is submitted as a part of the request by this Federally Qualified Health Center for reimbursement under the Mississippi Medicaid Program.

I HEREBY CERTIFY that I have examined the contents of the accompanying cost report to the State Mississippi, Office of the Governor, Division of Medicaid for the period stated above and certify to the best of my knowledge and belief that the said contents are true and correct statements prepared from the books and records of this center in accordance with applicable instructions.

(Signed) _____
Officer or Administrator of Provider

_____
Date

Cost Report Prepared By:
Name _____
Address _____
_____
_____
Name of Contact Person _____
Telephone Number _____

NOTE: Please attach accountants' report, if applicable.

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
FEDERALLY QUALIFIED HEALTH CENTERS

STATISTICAL DATA

PROVIDER NAME

PROVIDER NUMBER PERIOD: From To

1. Type of Control (Check One):
   Voluntary Nonprofit Corporation: [ ]Church [ ]Other
   Government Operated: [ ]State [ ]County [ ]Federal
   [ ]City [ ]Other

2. FQHC Owner:

3. Names of Other Federally Qualified Health Clinics In Mississippi Owned By The Above:

4. Accounting Basis: [ ]Accrual

5. Names of Physicians Furnishing Services at the Federally Qualified Health Center or Under Agreements (As Described In Instructions) and the Medicaid Provider Number of Each:

Physician	Medicaid Provider Number	Staff	Contract

FORM 3

Transmittal 90-08

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
FEDERALLY QUALIFIED HEALTH CENTERS

RECLASSIFICATION & ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

Provider Name
Provider Number Period:From To

Line No.	DIRECT HEALTH CARE COSTS Cost Center	Compen-sation Including Benefits Column 1	Purchased & Contract Services Column 2	Other Column 3	Total Column 4	Reclassi-fications Column 5	Total Expense (unadj.) Column 6	Adjust-ments Column 7	Total Expense Column 8
1	CORE HEALTH CARE COSTS:								
1-01	Medical								
1-02	Laboratory - Medical								
1-03	X-Ray - Medical								
1-04	Medical Social Service								
1-05	Psychology								
1-06	Other (Attach Schedule)								
1-07	Total Core Health Care Costs								
2	OTHER AMBULATORY SERVICES:								
2-01	Pharmacy								
2-02	Dental Services								
2-03	Optometry								
2-04	Durable Medical Equipment								
2-05	EPSDT Treatment Services								
2-06	Other (Attach Schedule)								
2-07	Total Other Ambulatory Services								
3	Total Direct Health Care Costs								

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
FEDERALLY QUALIFIED HEALTH CENTERS

RECLASSIFICATION & ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

Provider Name									
Provider Number		Period:From		To					
Line No.	Cost Center	Compen-sation Including Benefits Column 1	Purchased & Contract Services Column 2	Other Column 3	Total Column 4	Reclassi-fications Column 5	Total Expense (unadj.) Column 6	Adjust-ments Column 7	Total Expense Column 8
4	CLINIC OVERHEAD COSTS								
4-01	Administration								
4-02	Depreciation & Amortization								
4-03	Financial								
4-04	Insurance - General								
4-05	Insurance - Malpractice								
4-06	Interest - Mortgage								
4-07	Interest - Other								
4-08	Legal								
4-09	Maintenance & Repairs								
4-10	Medical Records								
4-11	Rent								
4-12	Security								
4-13	Supplies								
4-14	Telephone								
4-15	Utilities (Power, Gas, Water)								
4-16	Other (Attach Schedule)								
4-17	Total Clinic Overhead Costs								

FORM 4 - PAGE 2 OF 3

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
FEDERALLY QUALIFIED HEALTH CENTERS

RECLASSIFICATION & ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

Provider Name									
Provider Number		Period:From		To					
Line No.	Cost Center	Compen-sation Including Benefits Column 1	Purchased & Contract Services Column 2	Other Column 3	Total Column 4	Reclassi-fications Column 5	Total Expense (unadj.) Column 6	Adjust-ments Column 7	Total Expense Column 8
5	NON-REIMBURSABLE COSTS								
5-01	Bad Debts								
5-02	Community Services								
5-03	Contributions								
5-04	Education - Health & Other								
5-05	Environmental & Research								
5-06	Hearing								
5-07	Outreach								
5-08	Patient Transportation								
5-09	Pharmacy								
5-10	Podiatry								
5-11	Therapies								
5-12	Other (Attach Schedule)								
5-13	Total Non-Reimbursable Costs								
6	Outstationed/Eligibility Workers								
7	TOTAL COSTS								

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Transmittal 90-08

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
FEDERALLY QUALIFIED HEALTH CENTERS

PROVIDER STAFF, VISITS AND PRODUCTIVITY

Provider Name										
Provider Number		Period: From		To						
PART A – FQHC PROVIDER STAFF AND VISITS										
		FTE Personnel			Visits					
					All visits			Title XIX Visits		
	Positions	Under Agrmnt 1	Staff 2	Total 3	On Site 4	Off Site 5	Total 6	On Site 7	Off Site 8	Total 9
1	Physicians									
2	Midlevels									
3	Subtotal									
4	Dentists									
5	Dental Hygienists									
6	EPSDT Services									
7	Family Planning									
	Med. Soc. Workers									
	Pharmacy									
10	Psychiatrists									
11	Psychologists									
12	Therapists									
13	Other (Schedule)									
14	Total									

PART B – MINIMUM MEDICAL TEAM PRODUCTIVITY	AMOUNT
1. Total Physician and Midlevel Visits (Form 5, col. 6, line A3)	
2. Total Medical Team FTE's (Form 5, col. 3, line A1 plus one-half line A2)	
3. Minimum Medical Team Productivity (Line B2 times 3,500)	
4. Physician and Midlevel Visits to be Used In Rate Determination (Greater of Line B1 or B3)	

PART C – PROVIDER VISITS FOR RATE DETERMINATION	AMOUNT
1. Total Provider Visits Less Physician and Midlevel Visits (Form 5, col. 6, Line A14 less Form 5, col. 6, Line A3)	
2. Total Provider Visits for Rate Determination (Form 5, line C1 plus line B4)	

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STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
FEDERALLY QUALIFIED HEALTH CENTERS

OVERHEAD ALLOWABILITY AND RATE DETERMINATION

Provider Name

Provider Number **Period:From** **To**

PART A – DETERMINATION OF ALLOWABLE OVERHEAD COSTS		**AMOUNT**
1. Total Direct Costs of FQHC Services	(Form 4, line 3)	
2. Outstationed/Eligibility Workers Cost	(Form 4, line 6)	
3. Total Non-Reimbursable Costs	(Form 4, line 5-13)	
4. Total Overhead Costs	(Form 4, Line 4-17)	
5. Total Costs	(Sum of Lines A1, A2, A3 and A4)	
6. Screening Guideline for FQHC Overhead Cost		30%
7. FQHC Overhead Guideline Amount	(Line A5 Multiplied by Line A6)	
8. Allowable Overhead Cost	(Lesser of Line A4 or Line A7)	

PART B – ALLOCATION OF OVERHEAD TO FQHC SERVICES COSTS		**AMOUNT**
tal Direct Costs of FQHC Services	(Part A, line 1)	
2. Outstationed/Eligibility Workers Cost	(Part A, line 2)	
3. Subtotal	(Line 1 plus Line 2)	
4. Total Costs Excluding Overhead	(Part A, Line 5 minus Part A, Line 4)	
5. Direct Cost Ratio	(Line 3 divided by Line 4)	
6. Total Allowable Overhead Costs	(Part A, Line 8)	
7. Overhead Costs Applicable to FQHC Services	(Line 5 times Line 6)	

PART C – DETERMINATION OF TOTAL ALLOWABLE FQHC COSTS		**AMOUNT**
1. Total Direct Costs of FQHC Services	(Part A, Line 1)	
2. Overhead Costs Applicable to FQHC Services	(Part B, Line 7)	
3. Total Allowable FQHC Costs (excl o-s/elig. wrkrs)	(Line 1 plus Line 2)	

Date Received 6-30-93
Date Approved 2-18-93
Date Effective 6-30-93

OVERHEAD ALLOWABILITY AND RATE DETERMINATION

Provider Name		
Provider Number	Period:From To	
PART D - DETERMINATION OF FQHC RATE		AMOUNT
1. Total Allowable FQHC Costs (excl o-s/elig wrkrs)	(Form 6, Part C, Line 3)	
2. Total Provider Visits for Rate Determination	(Form 5, Line C2)	
3. Computed FQHC Rate Per Visit	(Line 1 divided by Line 2)	
4. Outstationed Eligibility Worker Cost	(Form 6, Part A, Line 2)	
5. Total Medicaid (Title XIX) Visits	(Form 5, Part A, column 9, line 14)	
6. Outstationed Eligibility Workers Addend to Computed FQHC Rate Per Visit	(line 4 divided by line 5)	
7. FQHC MEDICAID RATE PER VISIT	(Line 3 plus Line 6)	

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